Petition to ADD
The University of Chicago Student Health Insurance Plan
after the Published Enrollment Deadline

Student's Name: _____   Student ID: _____   Date of Birth: ___/___/_____

Mailing Address: _____

Phone Number (_____)_____   Effective Term: (circle one)   Autumn   Winter   Spring   Summer

Please fill in all of the above information so we can contact you with any questions.

Spouse/Domestic Partner's Name: _____   Spouse/Domestic Partner's Date of Birth: ___/___/_____

Child's Name: _____   Child's Date of Birth: ___/___/_____

Child's Name: _____   Child's Date of Birth: ___/___/_____

Child's Name: _____   Child's Date of Birth: ___/___/_____

I hereby petition to be allowed to enroll in the student health insurance program due to the following qualifying life change:

☐ Recently married or registered same sex domestic partner
(must provide copy of marriage license or domestic partner statement from University Human Resources)

☐ Change in employment of Spouse or registered same sex domestic partner (i.e. loss of job)
(must provide letter from previous carrier indicating termination date under their plan)

☐ Aged off my parents insurance plan
(must provide letter from previous carrier indicating termination date under their plan)

☐ Other, please provide explanation below

_____

_____

_____

_____

_____

Your coverage, if approved, will commence on the day your previous insurance terminates or the day after the post mark date of this request (whichever is later). You will be responsible for the full premium of the quarter in which your coverage is effective. Premium is not pro rated. If requesting to add due to loss of coverage, you are required to send confirmation of your termination from your prior carrier. This request cannot be processed without that information.

Premiums are assessed in 3 installments during the academic year. These charges are typically added to Autumn, Winter, and Spring bills. However, students and/or dependents beginning enrollment in the Winter or Spring quarters will be charged a Summer quarter premium.

_____   _____
Date   Student Signature

By checking "YES", I give the Registrar's Office permission to share my **health insurance enrollment information** with   ☐ YES   ☐ NO
University of Chicago student health services as well as Mercy Hospital (the provider of in-patient psychiatry services for U Chicago students). The purpose of this disclosure is to expedite the verification of student insurance status and thereby enable faster access to health care.

Students: Complete this form and return it to: **On-Campus Insurance Office**
Woodlawn Social Service Center
950 E. 61st Street, Suite 300A
Chicago, IL 60637

◖ UnitedHealthcare®

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